



TRAUMA AND INJURY INTELLIGENCE GROUP (TIIG)

SEMINAR AND WORKSHOP EVENT (27 June 2002) REPORT WRITE UP

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INTRODUCTION

The Trauma and Injury Intelligence Group (TIIG) Seminar held on 27 June 2002 at the Fire Service Training Centre focussed on the Injury Information Systems Development Project. Invitations were extended to representatives across Merseyside from Primary Care Trusts, A & E Departments, Police, Ambulance, Fire Service, Community Safety, Sure Start, Age Concern, Housing Associates and others having injury prevention within their remit. Previous work on behalf of the TIIG encompassed the development of a database of information and intelligence initiatives within Merseyside, the North West and nationally by the North West Public Health Observatory¹. A scoping project, commissioned from Mark Haig Associates, resulted in the findings of a lack of good quality local data to be used in planning, monitoring and evaluation of injury prevention initiatives. It was against this background the Injury Information Systems Development Project was initiated and funding accessed from Merseyside Health Action Zone, the Safer Merseyside Partnership and the Home Office's Robbery Fund. Two Project Officers were recruited in Autumn 2001 to take the project forward and it was felt to be an appropriate time to hold a Seminar with the following aims:

- Raising the profile of the Trauma and Injury Intelligence Group
- Motivate and involve key stakeholders - both users and providers of data
- Consult and involve the wider public health community

To achieve the stated aims the seminar was devised to consist of presentations and workshops. The Trauma and Injury Intelligence Group (TIIG) is one of four sub-groups of the Merseyside Accident Strategy Coordinating Group (MASCG), the other three have an injury prevention focus and are structured by population groupings. Workshops were therefore planned to reflect the sub-groups whilst focussing on priority injury issues within each group. This report contains copies of the presentations and also findings from the workshops. A summary of findings and action points are also included.

¹ Online database of Public Health Information www.nwpho.org.uk/information

SEMINAR FORMAT

The Seminar was planned to maximise use of time by the multi-agency representatives it attracted from across Merseyside. This is reflected in the programme (appendix 1) which had the following learning outcomes.

Following the seminar attendees should have:

- An appreciation of the origins and development of the Injury Information Systems Development Project
- An understanding of the importance of intelligence in the prevention of intentional and unintentional injuries
- Had an opportunity to comment on and be involved in the development of the Injury Information Systems Development Project

Dr John Reid acting as chair opened the Seminar and provided a brief outline of the project.

The keynote speakers were chosen to give practical examples of how intelligence had supported injury prevention initiatives. Mr Paul Joy from the Merseyside Fire Services drew upon his work in fire prevention to explain the use of data to inform planning of an Electric Blanket Safety Campaign on Merseyside in 2001 (appendix 2). A major influence in the development of the Injury Systems Development Project was the work of Chris Young from the University of Liverpool on the collection of assault data. This was included in his presentation entitled Health Agency data in Crime Reduction on Merseyside (appendix 3). Mr John Douglass as the Technical Development Officer on the project provided an overview of the development and the progress to date with specific reference to the development of a core data set (appendix 4).

The workshops, which were structured to reflect the age related subgroups of the MASCG, were focussed as follows: Children (with a focus on RTAs), Young Adults (with a focus on alcohol) and Older People (frail and vulnerable populations).

A plenary session allowed for feedback from groups and questions to be taken from the floor.

WORKSHOPS

Each of the three workshops had an identical structure and posed questions to be explored within small groups. The transcript of responses have been included in full to allow for transparency. In the summary major themes have been identified and this has enabled conclusions and action points to be extracted. As seminar attendees were drawn from a variety of agencies and disciplines, including both providers and users of data, an attempt to balance the groups was made to allow for an inter-disciplinary focus. The questions were as follows:

Question 1

What problems do you currently experience with accessing data on injuries for use in injury prevention?

Question 2

What information do you need to target interventions more effectively?

Question 3

What opportunities do you see to improve the provision of information in respect of intentional and unintentional injuries?

Workshop: Children [focus on Road Traffic Accidents]

The group addressed the issue of injuries in the under 15 year age group. Road traffic accidents (RTAs) are the leading cause of deaths throughout childhood. Furthermore, during 1998 it was found that 5,448 children in the under 15 year age group were seriously injured on British roads. However, it is thought there may be under-reporting in cases where no motor vehicles are involved (BMA 2001). It is for these reasons the focus of the workshop was selected.

Responses to Question 1 – What problems do you currently experience with accessing data on injuries for use in injury prevention?

Police and health data don't tie up:-

Police-Location

Health-address-(ambulance data: copy available)

Discrepancies re severity ISS (Injury Severity Score) – health
KSI – police

Extent/type of accident not known to both agencies

Ethical, etc issues of sharing information

Different methods of storing information in the various
agencies/compatibility

Systems/definitions change over time

Definition of terminology

Access to the information

Quality of the information type

Response/flexibility

Number of data items requested

Most appropriate time for collecting data items

Other routes of obtaining data (not A&E)

Small geographical areas (Sure Start)

Responses to Question 2 – What information do you need to target interventions more effectively? (RTAs)

Age

Postcodes

Targets set for difference Agencies (co-ordinating this information)

Inter-agency liaison

Specific location of accident (it was noted Police have this – Safety Services, but relates to engineering/education to respective roles in 2 or more organisations)

Home address (social class etc)

Severity

Information to set priorities – other agencies, etc also M&E

More reliable data – if collected later

Type of injury

Seasonal analysis and trends analysis for targeting interventions

Postcode of incident

Activity eg quad bikes

International Classification of Diseases version 10 Codes (definition of terminology) - shared and clear no jargon)

Postcode of resident

Knowledge of other initiatives eg Lancs. Partnership

Roles of different organisations - shared information

Access to information

Quality of information

Knowing other agencies targets as we all have different

Responses to Question 3 - What opportunities do you see to improve the provision of information in respect of intentional and unintentional injuries?

Trauma and Injury Intelligence Group (!) opportunity to co-ordinate efforts in a different way

National Accident Task Force - implementation of report and recommendations

Our Healthier Nation

National Targets

? Funding opportunities

World Health Organisation Guidelines?? Not seen yet/potential

Initiatives such as Lancashire Partnership/setting off etc?

Neighbourhood traffic schemes

Inter-agency Liaison

Common language

Common data set

Data to raise the profile of injury

Networking, contacts and Email

Division of data items

- at registration
- after/during treatment

A & E Reception Environment

Separate forms for assaults - not at registration

Advertising of Sure Start with A & E

- making links to other initiatives relevant to injury occurred

Fun ways of collecting data with children

Workshop: Young Adults [focus on alcohol issues]

The group addressed the issue of injuries in the 15 – 24 year age group. The World Health Organisation (WHO) is due to launch its first report on Violence and Health in 2002. Furthermore, it has been suggested that there is a strong correlation with alcohol and violence (BMA 2001). There are increasing levels of concern in respect of alcohol and young people and therefore this issue was chosen for the focus of the workshop.

Responses to Question 1 – What problems to you currently experience with accessing data on injuries for use in injury prevention?

Don't know what is there

Understanding requirements – negativity from providers

Confidentiality – knowing what is personal data

Consistency and comparability

Inhibitions when collecting data

Lack of IT access

User friendliness of historic systems

Aggregation of data – data detail at geographical level

Data analysis

Follow-up systems (what action has been taken following an injury)

Dissemination – internal communications

Timeliness of data

Inter-agency working – boundaries between departments

Responses to Question 2 – What information do you need to target interventions more effectively?

Minimum data set – except require specific names e.g. licensed premises, streets – dates, times

Active on-line surveillance system – two-way communication 'live'

Tying up the data with eventual interventions

Shared responsibility

Private sector involvement should be increased. Thinking outside of our box!

E.g. supermarket/off-licence data bases?

Trends, anticipation – be pro-active, make more of the data archive

Key Performance Indicators linked to data collection.

Responses to Question 3 – What opportunities do you see to improve the provision of information in respect of intentional and unintentional injuries?

Joint agency group for feedback and follow-up action points

Local Strategic Partnerships (LSPs)

Think regionally

Automated data flows to increase speed

Clear protocols

Regular Seminars

Workshop: Older People [focus on the frail and vulnerable]

This group addressed the issue of injuries in the over 65 year age group.

Demographic change is likely to result in an increase in the number of frail and vulnerable in the population. As the age in the population increases so does the burden of injury on individuals, families and carers thus injuries in the elderly impact on society as a whole. Prevalent unintentional injuries in this group include fire-related injuries and falls. It has been highlighted that 30% of people 65 years and older fall each year, rising to 50% in the age group 80 years and over.

Responses to Question 1 – What problems do you currently experience with accessing data on injuries for use in injury prevention?

Data required at various (geographical, age group, etc) levels by different users, including possible need for data on individuals (Caldicott permitting) to enable design of specific care packages

Lack of knowledge at basic level in some organisations of just what data is already available and how it can be accessed (especially likely in new organisations such as PCTs)

Often don't know what individual pieces of information are needed prospectively so tendency to over-collect but then not know what to do with it all

Data collection by different agencies not joined up – leads to duplication and gaps

Lack of continuity caused by hand-overs e.g. Ambulance Service and A & E Departments, or lack of standardisation between different parts of the same service e.g. different A & Es, causes problems when trying to use data for operational planning.

Police Officers sensitive – guess age this affects quality of data as they do not want to ask

Data varies depending on report/recording mechanisms eg visitors or neighbours may report; better locational data is available if patient brought to A&E by ambulance

Data on location of accident is notoriously difficult to collect and capture if accident happens outside the home.

No standardisation required in A&Es

Don't know what we need to look for – problem must be identified to begin to collect data on it

Don't ask right (critical) questions – may present with a different complaint (eg painful wrist), but have fallen (and do not tell staff that)

Problem due to reactive nature – group mainly 'pick up pieces'

A&Es collect data for purposes of effectively picking up the pieces (treating patients), not for preventing injury.

Cannot undertake direct referrals (Caldicott)

Responses to Question 2 – What information do you need to target interventions more effectively?

Robustness of data needs to be guaranteed – accurate, meaningful and timely data required for planning purposes

Temptation to keep adjusting the data kept over a period of time should be resisted – need stability in order to allow monitoring of the impact of planned (or unplanned) changes.

More detailed data on possible contributory factors for falls in older people needed in order to allow the development of a programme of planned prevention eg for falls in the home – did the person slip on a mat? trip over a trailing flex? fall on the stairs with no handrail, etc?

Data doesn't allow location to be recorded eg 'Borough Road'

Data from a number of sources – different methods and recording:

- Six Sigma?
- Elderly standardisation – Electronic Patient Record
- Need information for use in A & E (Medical) eg drug list
poly-pharmacy – taking a number of drugs at once causes falls

Uses of data:

- Exploration of injuries
- Co-ordinate responses
- Prevention of injury
- Break down injuries into types of injury

Use of ambulance data

Need to review data on a regular basis – reactive, then categorise

Responses to Question 3 - What opportunities do you see to improve the provision of information in respect of intentional and unintentional injuries?

Strong feeling that existing information would be improved by better training of data collectors, and in particular engaging them over the value of the information they collect to service planning

Too much collection of data to 'feed the beast'

Potential causes of falls in young people is higher - fewer lifestyle range in elderly not alcohol/drug use etc? Mainly in home in all groups where they happen - anecdotal supported by data but aids targeting of resources and data collection.

Example of fire service reduction in fires associated with electric blankets very powerful - if AED clerk understood that the bits of data they collected routinely would lead to such impressive outcomes then they are much more likely to collect that data accurately and fully

Do we ever feedback this type of outcome to the staff who have collected the data in the first place (and without whom we wouldn't have the data to make the changes that lead up to the impressive outcomes?)

Specialist Nurses will be able to gather more as the National Service Framework unfolds.

The availability of a gazateer of street names would aid the collection of locational information in A&Es (at registration desk). This would encourage street names to be entered onto the IT system, prevent misspelling and remove the need for freetext fields in the IT system.

SUMMARY OF FINDINGS

Findings from the workshops have been divided into 'Current Problems', 'Potential Solutions' and 'the Way Forward' to reflect responses to questions. Common themes and sub-themes could be traced in responses to workshop questions and these have been used to structure narrative and highlight issues relevant to the development of the Injury Surveillance System.

Current Problems

The first question discussed problems in accessing data for injury prevention work. At a basic level all three workshops highlighted simply knowing what information was available and from whom. There are traditional routes through which information flows - an example given in the workshops was Police RTA information through to Local Authorities for use in engineering and education interventions. However, as new organisations come into being, both Sure Start and Primary Care Trusts (PCTs) being cited, information may be required by a wider audience who may not be aware of sources.

Quality of data with analysis was also perceived as a difficulty particularly at a useable level, examples being activity, geographical and age-related. A particular problem with data about the location of the occurrence of injuries can be seen. However, the problem of incompatibility of data was discussed not only between agencies but also departments, and furthermore changes over time to systems and definitions are contributory factors. A specific example provided was the differences in severity of injury classifications.

Ethical issues were also cited in relation to confidentiality, access and data sharing. The following scenario, although prevented by Caldicott, is a very simple way to identify and target those at risk, from a potentially fatal house fire or a fall for example. This would be to refer the contact details of a patient to a risk assessment/injury prevention agency when they present with an injury that has been caused in similar circumstances. There are also issues surrounding the appropriate time to ask questions regarding an injury, particularly those of sensitive nature. An example given was police reluctant to ask age and preferring to guess. In some instances, it was noted, a neighbour or relative provides information on an injury and its accuracy may therefore be unknown.

It was felt sometimes in the dissemination of information that it failed to reach the right person and that this was exacerbated by failure of inter-agency working and crossing boundaries.

Potential Solutions

Secondly groups were asked to discuss what information they would require to target injury prevention more effectively. The emerging themes are categorised under headings.

Specific Information

Some of the specific information requirements have been addressed in the proposed data set (comments in brackets) or previously discussed. One group acknowledged that most of the requirements are on the data set with the proviso of more detailed location information, the example was 'Borough Road' or the name of licensed premises. The use of gazateers (e.g. attached to an A&E IT system) is seen as offering the potential to improve the quality of data covering the place of occurrence of injuries.

The importance of the following data items was stressed during the workshops:

- Dates and times (on proposed data set)
- Ages (on proposed data set)
- Postcode of usual address (Only to a given 'postcode sector' level to ensure confidentiality i.e. omitting the last two letters which would allow for identification of approximately 30 houses – postcode sector (approx 2000 homes) is on proposed data set)
- Home Address (This is unlikely due to issues of confidentiality, even though it was suggested that this may assist with social classification)
- Severity of injury (Indicated on data set through diagnosis and disposal)
- Type of injury (certain categories on data set)
- Postcode of incident (likely to be problematic if outside the home, as injured person would frequently not know)
- Activity (this needs to be addressed)
- ICD10 Codes (certainly would be useful and is requested, if possible, on data set).

Roles of Other Organisations

An understanding of the roles of other organisations was seen as important and it was felt that more inter-agency liaison would be useful and may engender a shared responsibility. Possible sharing of targets would develop an appreciation of how these could be met through inter-agency working.

It was also felt important to have an awareness of other initiatives, eg Lancashire Partnership.

Good Quality Information

There is a need to understand the uses of the data: exploration of injuries, co-ordinated responses and overall the prevention of injury when considering the provision of intelligence. The data should also be capable of being used for seasonal analysis and identification of trends. Furthermore, it should be pro-active and make use of the data archive.

Linkages

This was cited in two respects: firstly between information and outcomes, specifically Key Performance Indicators (KPIs) and secondly other data sources.

In the later category Ambulance data was noted, as was the standardisation expected through the Electronic Patient Record. The effect of poly-pharmacy on falls in the elderly was highlighted and whether it is possible to provide linkages via the drug lists. One group suggested potential links to the private sector in respect of alcohol and databases of sales should be explored.

System

This was discussed with the aspiration of an active on-line surveillance system with the capability of two-way communication. When discussing different methods and recording of data, the Six Sigma process, used in the private sector by Jaguar Limited, was highlighted.

Way Forward

Question three discussed opportunities to improve the provision of information. Again, common themes could be observed within the three workshops.

Strategies

A number of strategies likely to be influential in the future development of the project were highlighted. Amongst these were: Our Healthier Nation and the World Health Organisation Guidelines. It was also felt the implementation of the report and recommendations from the National Accident Task Force were important.

Organisations/Initiatives

The Local Strategic Partnerships were perceived as providing an opportunity as was the importance of thinking regionally. A number of initiatives were also discussed as providing opportunities, these included: Neighbourhood Traffic Schemes, Lancashire Partnership and the appointment of Specialist Nurses as the National Service Frameworks are implemented.

Strategic and Operational Issues

It was felt the Trauma and Injury Intelligence Group created an opportunity to co-ordinate efforts in a different way. Funding opportunities were cited as an issue and a number of operational issues to be addressed at different levels.

Data could be used to raise the profile of injury. Existing groups such as the Joint Agency Group for feedback could use feedback and follow-up of action points. Contacts could be maintained through regular seminars, networking and email. Automated data flows could be used to increase speed, but there is a need for clear protocols.

Use of a data set should be encouraged and would lead to use of common language. However, there are practical issues to be addressed. These include awareness of the A&E environment and the appropriate time to collect data items both at registration and after/following treatment. The view that a separate form for assaults should be used outside of registration was expressed.

Strong feelings were expressed regarding training for those collecting data and engaging with them to communicate why data is required, how it is used in targeting interventions. The results of any analysis should also be fed back to relevant staff. There is an opportunity to think differently eg a 'fun' way to collecting data with children.

ACTION POINTS

The following points emerged from the event as action points for the TIIG group. The TIIG steering group will therefore consider these points and appropriate action will be taken.

- Develop a Communication Strategy to ensure relevant agencies, organisations and partnerships are aware of the development of the Injury Information System and its ability to add value to their work. This strategy should include dissemination and maintaining contacts through various mechanisms.
- Revisit proposed data set to ensure that its content enables the issues raised in the workshops to be addressed.
- Promote use of the proposed data set to gather information and further explore the mechanisms for collecting the data items.
- Explore the provision of data at electoral ward level.
- Make A&E representatives aware of the content of the proposed TIIG data dissemination protocol.
- Ensure use of Expression of Interest Forms to facilitate the provision of a named person to receive TIIG reports in Organisations.
- Liase with A&E departments to offer appropriate briefing/training sessions to staff.
- Encourage inter-agency collaboration where appropriate (or where gaps are evident) on initiatives/projects attempting to reduce the incidence of injuries on Merseyside. In particular follow up the need for collaboration on sharing and understanding targets between agencies.
- Explore further sources of funding for the TIIG Project

EVALUATION

A standard evaluation form was included and items were kept to a minimum as also included in the pack was an Expression of Interest Form. This was for those wishing to be kept informed of the progress and provision to outline data requirements.

Unfortunately only a small number of evaluation forms were completed and returned. However, the majority of these indicate that presentations were useful or very useful. Comments on the Workshops in relation to whether they enabled exploration of issues in respect of data and injury included:

'Yes - contacts made'

'I would like to see more inter-action between data providers/ users if possible through extended workshops'

'Yes - generated a number of ideas and new contacts'

'Useful to hear from a mix of data providers and users'

'not really as we need to focus on the type of data to be collected/ provided. Would be useful to focus on the proposed core data set. Need also to know how to tie information into organisations who Focus on prevention and be more involved in campaigns/publicity etc'.

'insufficient time to allow discussion and debate'

The venue and programme content were judged to be good or excellent. All of these comments will be taken on board for future planning.